Perspective

Accountable Care Organizations and the Practice of Oncology

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Health care costs in the United States are continuing to rise at an unsustainable rate. In 2011, 17.9% of the US gross domestic product was spent on health care.[1] These costs are occurring across all components of the health care sector, but the costs for cancer care, especially for chemotherapy, are rising even faster.[2] Today, there are several chemotherapeutic medications with monthly costs exceeding $10,000.[3,4] If these expenditures were associated with high quality, cost-efficient care, one could argue on their value; however, the quality of cancer care in the United States has substantial room for improvement. Only 78% and 86% of patients with colorectal and breast cancer, respectively, received recommended care,[5] and patients often have false expectations regarding the effects of treatment.[6] Many newer drugs provide no significant benefit over older, less expensive agents. Care is perceived by patients to be impersonal. They have difficulty getting access to care, and even when they do get care, it is often poorly coordinated. The need to change our health care system is inarguable.

Over the past two decades, various approaches have been tried to modify the health care system. Health insurance reform through the establishment of health maintenance organizations succeeded in some regions but was not successful in others.[7] Although disease management programs focused on centralized support for complex conditions, few led to improved outcomes and reduced costs.[7] Value-based insurance design suggests that reducing copayments and deductibles for evidence-based care with a high return on investment will lead to better results.[8,9] But each of these proposals only addresses part of the problem, and controlling one component without addressing the others does not significantly reduce health care expenditures. More recently, the Physician Group Practice Demonstration Project showed that physician organizations could reduce the rate of increase in health care expenditures and maintain or improve the quality of care received by Medicare beneficiaries, especially among those with more complicated medical issues.[10]

This program served as the basis for Medicare's adoption of the idea of accountable care, whereby providers are accountable for the costs and care received by their patients. A driving force to encourage this adoption is payment reform, which aims to gradually shift the focus from a fee-for-service system with shared savings to a more capitated payment system. To ensure these savings are not achieved by reducing needed services, the amount of savings returned to physician groups is affected by the quality of care provided by the group, and there is public reporting of the quality and costs of care.

Accountable care organizations (ACOs) are groups of primary care physicians, nonprimary care physicians, and other health care providers, potentially including hospitals, who work together to avoid duplication of services, prevent medical errors, provide high-quality care, and lower the cost for health care.[12] These organizations must have a leadership committed to improving value for their patients, the skills and infrastructure necessary to manage the financial risk of this new model, an information technology system capable of processing internal and external data, and the ability to deliver key information to providers and patients.[13] These goals are consistent with the "triple aim" of improving the care of an individual patient, improving the care of the overall population, and reducing health care expenditures.[14]

The basis for any ACO is to provide effective primary care. Improving access to primary care (through use of e-mail, telephone support, physician extenders) and coordinating the care of patients with complex illness is hoped to lead to fewer preventable emergency department visits, hospitalizations, and readmissions. Delivering timely patient information to front-line personnel may decrease unnecessary testing and improve chronic disease management.

Medicare is supporting three different ACO models: (1) the Pioneer ACO,(2) the Medicare Shared Savings Program, and (3) the Advance Payment ACO. Commercial insurers have developed programs based on similar principles. In Massachusetts, the Alternative Quality Contract has lowered the rate of growth of health care spending and improved the quality of care.[14] A pilot ACO program sponsored by Blue Shield of California has slowed the growth of health care spending.[15]

ACOs can provide some benefits to participating physicians. One of the key benefits may be through their information technology systems. Health information exchange can assure that all providers across a community have access to the same patient information. Interoperable electronic health systems can be accessed in both inpatient and outpatient settings to allow better care coordination. Patient portal and personal health records may lead to increased patient engagement in their own care and educational opportunities. Data analytics can be used to profile physicians and patients. This information may also be used to qualify providers for Physician Quality Reporting Initiative and meaningful use incentives. Other benefits may include the sharing of evidence based guidelines, quality assurance activities, and better coordination of survivorship follow-up between primary care providers and oncologists.

A key question for oncologists is what role will they play in an ACO if it is so focused on primary care. Patient assignment is unlikely to be based on the care provided by oncologists. Although oncologists may have an ongoing relationship with a

patient, many of these are more limited in time and scope than those with a primary care provider. Oncologists may be involved in governance and participate in shared savings program, but this will likely depend on the relationship of the oncologist to the group forming the ACO. In an integrated delivery system, such as an academic medical center or large multispecialty group, oncologists will be part of the group deciding whether to form an ACO and will take part in decisions made by the ACO. In other situations, oncologists may contract with the ACO to deliver care to their shared patients with cancer.

But ACOs may not want to contract with all oncologists or cancer centers. As they strive to meet the triple aim, ACOs will focus on those oncologists or groups that provide the best value for their patients. Smith and Hillner[16] proposed five ways oncologists could demonstrate this value, including limiting chemotherapy to patients with good performance status, using second-line agents as monotherapy for metastatic solid tumors, and performing surveillance imaging only when there is clear evidence supporting this testing.

Oncologists might also work together to develop a medical home for some of their patients.[17] Although many patients with cancer are monitored for extended periods of time, that care is usually focused on the management of their cancer. One exception might be patients who have undergone bone-marrow transplantation. For these patients, the oncologist might serve as the patient's medical home as they may provide more comprehensive care for these patients. But if oncologists want to serve in this role, they must be prepared to provide continuous and comprehensive care, including preventive care, acute care, chronic disease management, and end-of-life care, as well as to help coordinate any of their patients' needs with other health care providers. This type of role would be associated with a monthly medical home payment to the providers. In a fee-for-service system, this would be in addition to their routine payments.

For other patients, oncologists and their staff might serve as care managers. By consulting more with their primary care colleagues and managing the adverse effects that their patients experience as a result of cancer treatment, oncologists can improve the overall quality of care their patients receive.[18] To cover these services, oncologists might receive a monthly care management fee. If these efforts lead to reductions in preventable emergency room visits or hospitalizations, savings might be shared with the physicians through a bonus payment.

Participating in clinical pathways programs may help reduce costs of care.[19] In these programs, a group of physicians typically works with a payer to identify chemotherapeutic regimens for specific cancers. If several regimens have similar clinical results, the least expensive option is selected. Such pathways have been associated with reductions in health care expenditures.[20,21] ACOs would benefit as lower costs could lead to shared savings for them with insurance companies; providers may receive a portion of these savings.

Finally, physicians could consider accepting bundled payments, which are designed to combine the payments to hospitals and physicians for a set of related services for a single episode of care into a single payment.[22] Through this mechanism, financial incentives are created to reduce the number and cost of services in the bundle through improved coordination of care among providers and with hospitals or cancer centers. In oncology, United Healthcare has studied providing bundled payments to cover drug costs and case management for specific stages of certain cancers.[23] Some bundled payment programs, such as in the Medicare sponsored Heart Bypass Center Demonstration project, have shown significant decreases in costs of care.[24]

ACOs now seem firmly entrenched in the health care system. As of January 2013, more than 4 million Medicare beneficiaries were participating in a pioneer ACO, Medicare Shared Saving Program, or advance payment ACO.[25] Millions of other Americans are participating in such programs through commercial insurers. Oncologists must decide how to work with these organizations while ensuring high-quality care to their patients and controlling the growth of health care expenditures.

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References

1. Hartman M, Martin AB, Benson J, et al: National health spending in 2011: Overall growth remains low, but some payers and services show signs of acceleration. Health Aff (Millwood) 32:87-99, 2013

2. Mariotto AB, Yabroff KR, Shao Y, et al: Projections of the cost of cancer care in the United States: 2010-2020. J Natl Cancer Inst 103:117-128, 2011

3. Bach PB, Saltz LB, Wittes RE: In cancer care, cost matters. New York Times, October 14, 2012, p A25

4. Siddiqui M, Rajkumar SV: The high cost of cancer drugs and what we can do about it. Mayo Clin Proc 87:935-943, 2012

5. Malin JL, Schneider EC, Epstein AM, et al: Results of the National Initiative for

Cancer Care Quality: How can we improve the quality of cancer care in the United States? J Clin Oncol 24:626-634, 2006

6. Weeks JC, Catalano PJ, Cronin A, et al: Patients' expectations about effects of chemotherapy for advanced cancer. N Engl J Med 367:1616-1625, 2012

7. Ellwood PM: Alternative delivery systems: Healthcare on the move. J Amb Care Manage 8(4):1-3, 1985

8. Bott DM, Kapp MC, Johnson LB, et al: Disease management for chronically ill beneficiaries In traditional Medicare. Health Aff (Millwood) 28:86-98, 2009

9. Chernew ME, Rosen AB, Fendrick AM: Value-based insurance design. Health Aff (Millwood) 26:w195-w203, 2007

10. De Souza JA, de Lima Lopes G Jr: Medicare reimbursement changes and the practice of oncology: Understanding the past is a key to the future. J Onc Pract 7:3067-308, 2011

11. Colla CH, Wennberg DE, Meara E, et al: Spending differences associated with the Medicare Physician Group Practice Demonstration. JAMA 308:1015-1023, 2012

12. Fisher E, McClellan M: Accountable care organization learning network toolkit. Washington, DC, The Brookings Institution, 2011http://www.acolearningnetwork.org/

13. Miller HD: Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care. Pittsburgh, PA, Center for Healthcare Quality and Payment Reform, 2011

14. Berwick DM, Nolan TW, Whittington J: The triple aim: Care, health, and cost. Health Aff (Millwood) 27:759-769, 2008

15. Song Z, Safran DG, Landon BE, et al: The 'Alternative Quality Contract,' based on a global budget, lowered medical spending and improved quality. Health Aff (Millwood) 31:1885-1894, 2012

16. Markovich P: A global budget pilot project among provider partners and Blue Shield of California led to savings in first two years. Health Aff (Millwood) 31:1969-1976, 2012

17. Smith TJ, Hillner BE: Bending the cost curve in cancer care. N Engl J Med 364:2060-2065, 2011

18. Casalino LP, Rittenhouse DR, Gillies RR, et al: Specialist physician practices as patient-centered medical homes. N Engl J Med 362:1555-1558, 2010

19. Bodenheimer T: Coordinating care—A perilous journey through the health care system. N Engl J Med 358:1064-1071, 2008

20. Feinberg BA, Lang J, Grzegorczyk J, et al: Implementation of cancer clinical care pathways: Successful model of collaboration between payers and providers. Am J Manage Care 18:e194-e199, 2012

21. Neubauer MA, Hoverman JR, Kolodziej M, et al: Cost effectiveness of evidence-based treatment guidelines for the treatment of non–small cell lung cancer in the community setting. J Oncol Pract 6:12-18, 2010

22. Richter-Ehrenstein C, Heymann S, Schneider A, et al: Effects pf a clinical pathway 3 years after implementation in breast surgery. Archive Gyn Obs 285: 515-520, 2012

23. Hussey PS, Mulcahy AW, Schnyer C, et al: Bundled payment: Effects on health care spending and quality. Closing the Quality Gap: Revisiting the State of the Science. Evidence Report/Technology Assessment No. 208. AHRQ Publication No. 12-E007-EF. Rockville, MD, Agency for Healthcare Research and Quality, 2012 www.effectivehealthcare.ahrq.gov/reports/final.cfm

24. Goozner M: United Healthcare, five oncology practices try bundled payments. J Natl Cancer Inst 103:8-10, 2011

25. Liu CF, Subramanian S, Cromwell J: Impact of global bundled payments on hospital costs of coronary artery bypass grafting. J Health Care Fin 27:39-54, 2001

26. CMS Media Relations: More doctors, hospitals partner to coordinate care for people with Medicare: Providers form 106 new accountable care organizations. http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date. Accessed January 28, 2013